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LEGAL REPRESENTATION FOR HEALTH CARE PROVIDERS AT ADVERSE PRIVILEGING HEARINGS

A Thesis

Presented to

The Judge Advocate General's School, United States Army

The opinions and conclusions expressed herein are those of the author and do not represent the view of either The Judge Advocate General's School, The United States Army, or any other governmental agency.

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38TH JUDGE ADVOCATE OFFICER GRADUATE COURSE

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LEGAL REPRESENTATION FOR HEALTH CARE PROVIDERS ADVERSE PRIVILEGING HEARING

by Major Robert L. Charles

ABSTRACT: This thesis examines the Army's regulatory restriction on legal counsel speaking for health care providers at hearings convened to consider limiting, suspending, or revoking clinical privileges. This regulation raises questions regarding the deprivation of fifth amendment due process rights to health care providers. The equity, justification, and wisdom of the restriction is questioned in light of the lack of such restriction in the other military services, recent federal legislation, and other Army regulations. This thesis concludes that there are strong legal, equitable, and common sense reasons to change the restriction to allow legal counsel to speak for health care providers.

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I. INTRODUCTION

Department of Defense (DOD) physicians received a lot of bad publicity in the 1980s. According to news reports, many patients in military hospitals and clinics were injured seriously by substandard treatment from unqualified physicians. These health care providers included some who joined government service to escape the consequences of adverse licensing and privileging actions and medical malpractice suits that arose from their previous civilian practices.[1]

The situation was scandalous: officials responsible for overseeing military medicine were exposed for neglecting the problems and for covering them up.[2] Many dissatisfied patients of military health care brought medical malpractice actions;[3] others complained to their congressional representatives. Members of Citizens Against Military Injustice (CAMI) were particularly vocal about their dissatisfaction.[4] CAMI supports legislation to repeal the Feres bar to recovery in tort for military members injured because of military medical malpractice.[5]

Responding to the clamor from their constituents, members of Congress held hearings with DOD health care officials and demanded that the quality of military medicine improve. Members of Congress were particularly concerned about the problem of substandard physicians in the military.[6] In response, DOD

officials directed the armed services to take more stringent measures to scrutinize the qualifications of physicians before they enter military service, and to ensure that these physicians provide good quality health care while in military practice.[7] Medical quality assurance measures have been given higher priority as a result. For its part, the Army recently published a new medical quality assurance regulation to carry out the directives from DOD.[8]

This thesis considers one aspect of the Army's procedures used to ensure that its physicians (and some other health care providers) provide quality health care. It focuses on the regulation that restricts legal representation at hearings convened to consider limiting, suspending, or revoking clinical privileging. Under this regulation, legal counsel may be present at these hearing to consult with the affected health care provider. However, legal counsel may not speak for the provider.

There are three possible reasons for the Army's current policy. First, not Congress, nor the federal courts, nor DOD has told the Army that it must allow such legal representation.

Second, there is always something to be said for limiting process. "Process is expensive and time-consuming. It generally does not assist an agency to accomplish its mission, and to the extent that it

diverts agency resources, it inherently impedes the agency's performance of its business."[9] For example, allowing Trial Defense Service (TDS) attorneys to represent health care providers in such cases would stretch their already heavily-loaded schedules. No doubt some delay would be entailed occasionally in granting TDS time to properly prepare.

Third, experience has shown that not all hospital commanders and senior military health care officials are wildly enthusiastic with lawyers in their domain. They fear that allowing lawyers to represent health care providers will turn professional peer review into nit-picking fights over legal technicalities.[10]

This thesis proceeds as follows: Section II details the regulatory system under which health care providers are granted permission to practice medical care in the Army. (This permission to practice medicine is termed clinical privileges.) Section III considers the bases for the Army to take away clinical privileges. It gives particular attention to the current, limited role of legal counsel for the responding health care providers in the administrative process.

Sections IV through VIII set forth the case for an expanded role for legal counsel in the administrative process. Section IV lays out a technical, legal argument for change. It examines whether the due process demands of the United States Constitution require a greater role for legal counsel than the

Army's regulation provides. This area is, admittedly, legally unsettled.

Section V explores a recent federal court case involving union representation of an Army civilian health care provider at an adverse privileging hearing. This case has resulted in a significant inroad against the Army's current position.

Congress recently passed legislation that sets out due process standards for adverse privileging hearings in the private medical sector. This new law addresses legal representation at those hearings as well. DOD implementation of this new law may require the Army to reconsider its current position. Section VI discusses the implications of this legislation.

Next, the thesis reviews the right to legal representation at adverse privileging hearings by the other federal agencies that provide health care. The Army is alone among the military services in denying its health care providers this important due process right. Section VII contains this review.

Last, the thesis considers some anomalies in the Army's administrative procedures regarding the right to representation by counsel. Section VIII contains an argument for a common sense reassessment of the health care providers' right to representation in light of these anomalies.

In Section IX the thesis concludes that there are strong legal, equitable, and common sense reasons to change the Army regulation to allow a greater role for legal representation at adverse privileging hearings. This thesis advocates granting the responding health care provider the right to permit legal council to act as the provider's spokesperson at these hearings.

II. BACKGROUND

The Secretary of Defense is responsible for overseeing the provision of health care to all eligible beneficiaries of DOD.[11] This responsibility includes ensuring that health care providers at DOD hospitals and clinics are qualified to provide health care. To carry out this important mandate, DOD has directed that "all health care providers be prepared by training, education, and experience for the scope of practice for which they are granted privileges."[12]

Clinical privileges are "permission to provide medical and other patient care services in the granting institution, within defined limits, based on the individual's education, professional license, experience, competence, ability, health, and judgment."[13] Only those health care providers with clinical privileges are authorized to make "independent decisions to diagnose, initiate, alter, or terminate a regimen of medical or dental care."[14]

The Secretary of Defense passed the responsibility for ensuring the proper issuance of clinical privileges to the secretaries of the respective military departments.[15] The Secretary of the Army, in turn, delegated this duty to the medical treatment facility (MTF) and dental treatment facility (DTF) commanders.[16]

Clinical privileges are institution specific; that is, a health care provider must be granted clinical privileges at each MTF or DTF where the provider works. There are two good reasons for this. First, it helps assure each facility commander of the qualifications of the facility's health care providers. Lax privileging standards have caused the Army Medical Department a great deal of embarrassment and congressional scrutiny in the recent past.[17]

Second, each MTF and DTF has distinct practice capabilities. Privileges should be granted only for those procedures done at each particular facility.[18] For example, many Army orthopedic surgeons are qualified to do complicated disc surgery on the spine. The support equipment and auxiliary personnel needed to support these complex procedures, however, are located only at the Army's teaching hospitals or Medical Centers (MEDCENs). Therefore, an orthopedic surgeon stationed at other Army hospitals (Medical Activities or MEDDACs) should not be given clinical privileges to perform these procedures. In this example denying

clinical privileges is not a negative reflection on the skills of the particular surgeons, but simply a recognition of the limitations of the MEDDAC.

The need to tailor clinical privileges to the qualifications of the health care provider and the capabilities of the facility means that privileges should reasonably detail the specific clinical procedures a health care provider is allowed to perform. For example, clinical privileges should not simply state a specialty such as "general surgery." Each clinical department in the facility is responsible for developing standards for granting clinical privileges.[19] Guidelines from national medical specialty boards are used by the clinical departments to develop their standards.[20]

Army regulations detail which health care providers need what kind of clinical privileges, and how they obtain them. Those health care providers who need authority to make independent decisions to begin or change a patient's care plan need individual clinical privileges. This is sometimes termed being "individually credentialed."[21] Under current regulatory guidance, health care providers needing individual privileges include: "physicians, dentists, nurse practitioners, nurse anesthetists, nurse midwives, podiatrists, optometrists, clinical social workers, clinical psychologists, and physician assistants."[22] Professionals in allied fields, such as physical therapists, occupational therapists, audiologists, clinical dieticians, clinical

pharmacists, and speech pathologist, may also be given individual clinical privileges.[23]

Other health care providers who participate directly in health care, for example, licensed vocational nurses and dental assistants, do not require privileging. Those health care providers function in support roles to individually privileged providers. Categorically credentialed health care providers are granted privileges to exercise judgment and perform procedures that come within the general area of competence of all those who fall within their same category because of similar training.[24]

There are five categories of clinical privileges granted to individually privileged health care providers:

(1) Courtesy privileges for those assigned for short periods;[25]

(2) Consulting privileges for visiting experts or consultants;[26]

(3) Temporary privileges for military health care providers arriving at new duty stations without their Provider Credential File (PCF);[27]

(4) Conditional privileges for health care providers who are just coming on active duty or starting employment with the Army, recently finished with specialty training in a new area, undergoing a period of remedial training, or returning to clinical practice after serving in a nonclinical capacity for more than one year;[28]

(5) Defined privileges for providers who complete the conditional period.[29]

Each health care provider is responsible for requesting the clinical privileges necessary to cover those medical activities the provider hopes to perform in the particular facility. The chief of the clinical department to which an individually privileged health care provider is assigned reviews the request, endorses it, or recommends changes. The chief then forwards the request to the facility's credentials committee.[30]

The credentials committee of a facility is generally composed of the chief medical or dental officers at the facility and such other personnel as the commander thinks appropriate. When the credentials committee acts upon the privileges of a nonphysician, the director or chief of service of the nonphysician sits as a member.[31] The chairperson of the credentials committee is either the deputy commander for clinical services (DCCS) at the hospital or the DCCS's designee.[32]

The credentials committee reviews the health care provider's request, the department chief's recommendations, and the PCF. Based upon their review, the committee makes a recommendation concerning privileges to the facility commander.[33] The facility commander has the authority to grant or refuse to grant privileges. The commander need not follow the credentials committee's recommendations.

III. ADVERSE PRIVILEGING ACTIONS

A. Bases for taking adverse privileging actions.

The health care facility commander not only grants clinical privileges, but the commander may also take them away.[34] The adverse withdrawal of clinical privileges can have a devastating effect on a health care provider's present and future ability to practice medicine. As will be detailed in Section IV, information of an adverse privileging action becomes available to potential employers in the medical and dental fields. Therefore, these actions should be taken most seriously.

Two broad bases exist for taking adverse privileging actions: nonclinical misconduct that reflects negatively on the health care provider's integrity or fairness, and substandard clinical performance.

1. Nonclinical bases.

DOD has prescribed many nonclinical acts for which adverse privileging actions ought to be considered.[35] These acts include:

* Cheating on a professional examination;

* Making false statements to patients regarding clinical skills or clinical privileges;

* Negligently or willfully violating patient confidentiality;

* Being impaired by drugs or alcohol;

* Wrongfully possessing or using a controlled substance;

* Aiding obviously impaired or incompetent providers to practice health care;

* Sexual abuse related to health care practice;

* Not reporting disciplinary action taken by professional or governmental organizations, and adverse malpractice judgments or settlements occurring outside DOD facilities;

* Committing felonies or serious misdemeanors.[36]

As is apparent from this list, which is not all inclusive, the conduct need not be related to questions of professional competence.

2. Clinical bases.

Allegations of substandard clinical performance surface to hospital authorities in numerous ways. One way is through the mandated peer review activities in areas such as medical and dental records, surgical cases, blood product use, and pharmaceutical use.[37] Monitoring and assessing clinical performance is carried out by the various medical Quality Assurance Program subcommittees.[38]

A second means by which substandard medical care comes to the attention of the facility command is through mandatory reporting and investigation of deaths and serious bodily injuries that may have been caused by negligence.[39] The patient care that gave rise to tort claims, patient complaints, and congressional inquiries is also reviewed for evidence of substandard care.[40]

B. Types of adverse privileging actions.

Clinical privileges may be limited, suspended, or revoked.[41] These adverse privileging actions may be taken in a summary or routine manner.

1. Summary actions.

Summary actions may be taken by the chairperson of the credentials committee or the commander.[42] Such actions are appropriate when: "1. A practitioner's conduct (or allegations thereof) requires that action to protect the health or safety of patients, employees, or others in the MTF or DTF. 2. A practitioner's involvement in (or alleged involvement in) an incident of gross negligence or acts of incompetence or negligence causing death or serious bodily injury."[43] Where there is an imminent threat to a patient, the department or service chief over the subject health

care provider has authority to take summary action. "In unusual situations, for example, inebriation or bizarre behavior, the senior medical officer available, of whatever grade, will have authority to act summarily."[44]

Whenever summary action is taken an immediate investigation is undertaken by an officer appointed by the credentials committee chairperson. The credentials committee reviews the full report of the investigation and makes a recommendation to the commander.[45] The health care provider is to receive a written notice within fourteen days of the summary action that specifies the deficiencies, limitations, suspension, and duration, and the right to a hearing before the credentials hearing committee.[46]

2. Routine actions.

Routine adverse privileging actions begin with information of health care provider misconduct or substandard clinical care coming to the attention of the credentials committee through any of the many channels described earlier. If the committee chairperson thinks more information on the allegations is needed, the chairperson may investigate the facts or delegate that duty to another.[47] In either case the investigator reports to the credentials committee.

After reviewing the report, the chairperson may recommend to the commander that no action be taken, initiate summary action, or put the matter before a hearing committee for review.[48] A hearing committee may also be convened at the request of the health care provider where summary action has been taken.[49] The credentials committee or some part thereof may act as the hearing committee.[50] "A member of the practitioner's discipline should also be a member of the hearing committee."[51]

The procedures of the hearing committee are informal. The rules of evidence prescribed for courts-martial are not applicable.[52] The hearing committee is charged with becoming "fully informed of the facts so that it may make an intelligent, reasonable, good-faith judgment. To become fully informed, the committee may question witnesses and examine documents as necessary."[53]

The hearing committee chairperson gives the health care provider written notice of the time and place of the hearing, the specific allegations to be examined, and the names of witnesses to be called. The health care provider is further informed of the right to be present during the proceedings, to cross-examine the hearing committee witnesses, and to call witnesses in the provider's own behalf.[54] The written notice also informs the health care provider of the right to "consult" legal counsel. As the regulation details it:

> The practitioner is free to consult with legal counsel or any other representative. While such

> representatives may attend the hearing and advise the practitioner during the hearing, such representatives will not be allowed to participate directly in the hearing (for example, they will not be permitted to ask questions, respond to questions on behalf of the practitioner, or seek to enter material into the record.[55]

In essence, legal counsel for the health care provider may not act as a spokesperson for the provider at the hearing committee proceedings. Legal counsel may whisper suggestions in the client's ear or pass along notes. The regulation implicitly permits the use of military counsel to consult with the health care provider.

After all the evidence has been presented, the health care provider (and counsel, if any) are excused while the hearing committee deliberates. A summarized record, or, at the chairperson's direction, a verbatim record is made.[56] No evidentiary standard or burden, for example, substantial evidence, is provided for in the regulation to support the hearing committee's findings. Recommendations for the commander are made by majority vote, through secret ballot, with no abstentions allowed.[57]

The hearing committee's recommendations may include the following: limiting the health care provider's clinical privileges, for example, the provider may be required to consult with other physicians on certain

types of cases, or to receive more education or training in the deficient area; reinstating, suspending, or revoking clinical privileges; or releasing the health care provider from active duty or employment.[58] The bases for the hearing committee's findings and recommendation should be documented from the evidence presented at the hearing.[59]

Where the hearing committee is not composed of all members of the full credentials committee, those remaining members of the credentials committee review the record, with its findings and recommendations. They may concur with the recommendations of the hearing committee or make separate recommendations to the facility commander.[60] A judge advocate legal sufficiency review is required before the commander takes action.[61]

The health care provider is given written notice of the commander's decision. If the decision includes adverse privileging action, the health care provider is advised of the right to appeal.[62] An appeal goes to the appropriate Medical Command (MEDCOM) commander.[63] The MEDCOM commander appoints an appeals committee to review the matter and make recommendations for the commander's action. The appeal is on the record; the regulation makes no provision for the health care provider or his representative to personally appear.[64] The health care provider may also appeal an adverse MEDCOM decision to The Army Surgeon General.[65]

IV. DUE PROCESS CONSIDERATIONS

A. Due process generally.

The fifth amendment to the United States Constitution provides, in part, that "No person shall . . . be deprived of life, liberty, or property, without due process of law."[66] As an agency of the federal government, the United States Army is required to meet due process requirements in its administrative procedures if an individual's constitutionally-recognized liberty or property interests could be subject to deprivation. The issue of legal representation for Army health care providers at adverse privileging hearings arguably implicates the due process clause.

Discussions of due process rights are normally broken down into two parts: substantive and procedural. Substantive due process is concerned with "the constitutionality of the underlying rule [being enforced] rather than with the fairness of the process by which the government applies the rule to the individual."[67] In essence, this means that the underlying law, regulation, or rule must not be arbitrary, capricious, or unreasonable.

"Procedural due process, on the other hand, requires that the Government afford persons the benefit of a certain amount of process (e.g., notice and a right to be heard) before taking away one of their constitutionally-protected interests. It does not prohibit the deprivation of protected interests; procedural due process simply mandates that before deprivation takes place, the requisite process be provided."[88]

The issue in this section is whether the due process clause requires that Army health care providers be permitted to have legal counsel represent them at hearing committee proceedings. The right to representation by counsel involves the process by which the health care providers' interests may be deprived and not the substance of the rules that allow the Army to deprive the providers of those interests. Thus, the issue here is one of procedural due process.

To determine if the right to representation exists under the due process clause requires a two-step analysis. First, is the interest we are concerned with, that is, clinical privileges, a liberty or property interest protected by the due process clause? Second, if the answer to the first question is yes, is the right to representation by counsel among the due process rights that must be followed?[89]

Army health care providers have both a liberty and a property interest in their clinical privileges which should be given procedural due process protection under

the fifth amendment.

B. The liberty interest.

1. Stigma.

A common liberty interest at risk in administrative decisions is stigmatizing an individual. "Generally, the Government may not stigmatize persons without giving them notice and the opportunity to be heard. Due process affords individuals an opportunity to clear their names--to be vindicated."[70]

The stigma, or damage to reputation, by itself, does not, however, implicate a liberty interest sufficient for the courts to invoke protections under the due process clause.[71] Three other conditions must be met. First, the governmental action must adversely affect "some more tangible interest such as employment."[72] Second, "the stigmatizing information must be made public by the offending governmental agency."[73] Third, the stigmatized individual must contest the truth of the stigmatizing information.[74] To assess whether an adverse privileging action implicates a constitutionally-protected liberty interest, the above three conditions will be analyzed in light of recent federal legislation.

2. The Health Care Quality Improvement Act of 1986.

The Health Care Quality Improvement Act of 1986 (Act)[75] was Congress's reaction to what it found to be two serious problems in the American health care arena. First, Congress found that there was an increasing occurrence of medical malpractice.[76] Effectively addressing this problem was complicated by the fact that physicians generally were failing to take adverse privileging actions against their incompetent colleagues. Physicians were failing in this duty out of fear of being sued themselves by those who professional conduct they were reviewing.[77]

Second, Congress noted also that there was no nationwide registry of health care providers who either had adverse privileging actions taken against them or who were involved in payouts from medical malpractice suits. The lack of a nationwide registry allowed some incompetent health care providers to continue malpracticing. They relocated to other licensing jurisdictions when their clinical privileges or professional licenses were revoked or threatened.

The Act takes a two-pronged approach to these problems. In order to encourage the desired adverse privileging actions, Congress created a broad immunity from liability for participants--hearing committee members, witnesses, and ultimate decision makers--in adverse privileging actions. As a prerequisite for gaining the immunity, the Act requires that certain due

process standards be met. This prong will be considered in greater depth later.

To stem the tide of itinerant medical malpractitioners, Congress directed the U.S. Department of Health and Human Services (DHHS) to establish the National Practitioner Data Bank.[78] Hospitals and insurance companies will report to the Data Bank the names of health care providers who have been subject to serious adverse privileging actions or who were responsible for medical malpractice payouts. The Data Bank will make this information available to health care facilities and state medical licensing agencies. Health care facilities and state medical licensing agencies are to use the information from the Data Bank in making their privileging and licensing decisions.[79]

The Act provides that the Secretary of Defense and the Secretary of the DHHS are to "seek to enter into a memorandum of understanding" (MOU) to apply the reporting provisions of the Act to DOD.[80] The parties signed the MOU on 21 September 1987.[81] DOD officials are preparing a directive to implement the MOU.[82]

3. The stigma analysis.

An Army health care provider has a protected liberty interest under the due process clause of the fifth amendment to the U.S. Constitution. The liberty interest is being free from imposition of an improper stigma. The information to be given to and disseminated from the Data Bank is stigmatizing. In essence, the adverse privileging information signifies that the health care provider has been deemed sufficiently incompetent, technically or morally, by his peers to limit, suspend or revoke his right to practice his profession--most assuredly that qualifies as a stigma.[83]

Not all government action that stigmatizes an individual, "however, gives rise to an infringement of a liberty interest set out under the due process clause."[84] The three conditions set out in subsection IV.B.1, above, must be met.

Clearly, one of Congress' intentions in establishing the Data Bank was to identify health care providers[85] who have had adverse privileging actions against them. Congress meant to restrict the ability of incompetent health care providers to move their professional (unprofessional?) practices to different areas without disclosure or discovery of their previous bad acts.[86] The dissemination of this stigmatizing information will effectively impede employment opportunities for health care providers whose names are in the Data Bank. Thus the first condition set out above will be satisfied.

DOD will participate in the reporting requirements of the Act. The reporting mechanism for getting stigmatizing information from the Army's health care facilities to DOD is already in place.[87] Health care facilities have a strong inducement to ask for the information from the Data Bank. A hospital that does not request the information in the Data Bank on a health care provider who applies for clinical privileges is presumed to have knowledge of any information in the Data Bank.[88] Such a presumption would make the defense of a medical malpractice suit alleging negligent hiring or privileging considerably more difficult. DOD will meet the second condition by disseminating the stigmatizing information.[89]

The last condition necessary for the freedom from stigma to qualify as a constitutionally-protected liberty interest is that the health care provider assert that stigmatizing information is false. If the health care provider asserts that the information is false, the Army should provide due process so that the provider can protect his reputation. Because adverse privileging action meets these stigma-creating conditions, there is a constitutionally-protected liberty interest.

C. The property interest.

A health care provider's medical privileges constitute a valuable property interest requiring due

process protection. For example, in Northeast Georgia Radiological Association v. Tidwell,[90] Dr. Horne, a radiologist, and his wholly-owned corporation entered into an service contract with Walton County Hospital Authority, a government agency. The contract provided for the corporation to give radiological services on a part-time basis. Under the terms of the contract, all employees of the corporation were required to have medical staff privileges at the hospital. It also provided for termination for cause. The contract incorporated the medical staff bylaws. These bylaws required notice and hearing within a seven-day period before staff privileges were terminated.[91]

Some five months after the start of the contract hospital authorities voted to hire another radiologist on a full-time basis and terminate Dr. Horne's corporation's contract. Accordingly, the hospital administrator wrote Dr. Horne and told him that the contract was terminated as were Dr. Horne's medical staff privileges. No pre-termination hearings were afforded either to the corporation, for its contract, or to Dr. Horne, for his medical staff privileges. Dr. Horne took the matter to court.

The court found that there was an explicit agreement between the parties providing for no termination of the privileges without notice and hearing. The agreement showed "the existence of rules or mutually explicit understanding . . . that create a [constitutionally-protected] property interest in these privileges."[92] The court went on to say, "Medical

staff privileges embody such a valuable property interest that notice and hearing should be held prior to its termination, absent some extraordinary situation where a valid government or medical interest is at stake."[33]

Section II set forth how the Army grants clinical privileges. These clinical privileges are the same as medical staff privileges. Both set out the clinical activities that the health care provider has been granted authority to undertake in the facility. Section III described the Army's procedures for taking away clinical privileges. The bases for taking away clinical privileges are misconduct or substandard care. The health care provider's regulatory right to a hearing was detailed. Because of the Army's explicit regulation establishing a causal basis for termination of clinical privileges, there is a constitutionally-protected property interest in them.

D. How much process is due?

1. Due process rights generally.

A health care provider needs procedural due process protections before the stigmatizing information is disseminated. This will best assure the health care provider an opportunity to defend his reputation against false allegations. Procedural due process

protections are also needed to ensure the fairness of the fact-gathering and decision-making processes of the government agency.

Section III covered those due process protections that the Army currently gives to health care providers in the administrative process when adverse privileging action is being considered. These protections include: written notice of the time and place of the hearing, details of the allegations which form the basis for the hearing, an opportunity to review all the medical records or other written evidence to be presented to the hearing committee, an opportunity to cross-examine the government's witnesses and to present witnesses on the provider's behalf.[84]

There is no mechanical way to determine which due process protections are required in every possible administrative process in which liberty or property interests are implicated. "The degree of process the Government must provide in any case is determined on an essentially ad hoc basis. There is no clear cut formula. The very nature of due process negates any concept of inflexible procedures universally applicable to every imaginable situation."[85]

The Supreme Court set forth three factors to weigh when judging which due process rights are required in a given case:

> To determine what process is due, three factors should be considered: First, the private interest that will be affected by the official action;

> second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute requirements would entail.[96]

These three factors must be balanced against each other. "The required degree of procedural safeguards varies directly with the importance of the private interests affected and the need for and usefulness of the particular safeguard in the given circumstances and inversely with the burden and any other adverse consequences of affording it."[97]

There is, thus, no clear cut formula to determine which due process protections must be provided by the Army at adverse privileging hearings. For that reason it is often difficult to decide when a hearing requires assistance of counsel.[98] Numerous court cases have considered the due process implications of hearings similar to the Army's adverse privileging actions for other federal and state agencies.[99] Only a few of these cases, however, have considered the issue of legal representation for the affected health care provider.

2. The right to legal counsel and the courts.

a. The federal court cases.

At least three federal courts have considered the issue of the right of representation by counsel for physicians facing adverse privileging actions by state agencies. Under the fourteenth amendment to the U.S. Constitution, states also must provide procedural due process before depriving persons of a protected liberty or property interest.[100]

The first federal case, Woodbury v. McKinnon,[101] was decided in 1971. Dr. Woodbury contended that officials at the Barbour County (Alabama) Hospital had denied him substantive and procedural due process in wrongfully depriving him of surgical privileges. Dr. Woodbury was allowed to have his attorney present to confer with him at the informal hearing of the medical staff members who considered his case. His attorney could not question the witnesses, but Dr. Woodbury could and did. This is similar to the Army's procedures.

The court found no due process violation in the limited role imposed on Dr. Woodbury's legal counsel. As the court saw it, "Dr. Woodbury was in a familiar setting, with familiar people, discussing a familiar subject. His expertise and acquaintance with the facts of each thoroughly qualified him to be effective in discussion with his fellow doctors."[102]

The Woodbury decision is of limited precedential value. The case is almost twenty years old, preceding major decisions on procedural due process made by the U.S. Supreme Court.[103] In addition, no witnesses were called at Dr. Woodbury's hearing. Thus, the court could not gauge any prejudicial effect that might have occurred had Dr. Woodbury been unable to effectively examine or cross-examine witnesses.

The one federal court case to hold that a health care provider was entitled to legal representation at an adverse privileging hearing was decided in 1983. In Mahmoody v. Alpina General Hospital[104] the court was convinced by the plaintiff/physician's poor English language skills that legal representation was necessary as a matter of fairness. Similar results would be warranted with many Army health care providers who have poor command of the English language.[105]

The last federal court case is a 1987 decision, Yashon v. Hunt.[106] Dr. Yashon, a neurosurgeon, brought suit after the medical staff administrative committee at Ohio State University Hospitals rejected his application for reappointment to the medical staff. He alleged, among other things, that the administrative hearing at which his application was rejected violated numerous due process safeguards, including denial of representation by counsel. Under the administrative rules Dr. Yashon's attorney was not allowed to attend the hearing. Dr. Yashon argued that this absence of

counsel increased the "risk of an erroneous deprivation of [his] interest," and that "the assistance of counsel was required to meet notions of fairness."[107]

The court rejected Dr. Yashon's argument for three reasons. First, according to the court, an individual was not entitled to representation by counsel at informal university proceedings. Second, Dr. Yashon had agreed prior to his hearing that no counsel would be present. Third, Dr. Yashon was unable to persuade the court that he was prejudiced by not being able to have counsel present. As the court saw it, Dr. Yashon was "conversant with all of the charges against him. Further, "since he was competent at cross-examination," "it was unlikely that the presence and participation of counsel on Dr. Yashon's behalf would have provided a procedure less likely to have resulted in erroneous findings of fact."[108]

Yashon does not have precedential value for the Army's position. For one thing, Army health care providers have not agreed not to be represented by counsel. For another, the court could only determine that Dr. Yashon was not prejudiced by lack of counsel after reviewing the hearing proceedings. Where a health care provider was less adept at defending himself or presenting his case the procedure would be more likely to result in an erroneous finding of fact.

One scholar summed up the federal courts' approach to our issue: "There is no Gideon case for medical

staff hearings."[109]

b. The state court cases.

State courts that review a private hospital's adverse privileging actions must also decide which due process rights should apply to the hospital's actions. When these courts do not consider the hospital to be acting as an agency or instrumentality of the state, then the majority of state courts take one of two approaches. Some courts will review the hearing proceedings to determine if the hospital followed its own bylaws. As long as the bylaws' procedures were followed, the hospital need not provide further protections. Other courts hold that the private hospital acts at its own discretion and is not subject to judicial review.[110]

A number of state courts have held, however, that even a private hospital's authority to take adverse privileging action is not completely discretionary. These courts will review the private hospital's action to see that "fair procedures" or "due process" were afforded to the affected health care provider.[111] The practical distinction between requiring a private hospital to afford "fair procedures" rather than "due process" as required by the fourteenth amendment is not always clear.[112]

In either case, these courts have reasoned that because the private hospitals operate in the public interest,[113] or use public money,[114] or receive preferential tax treatment, or some combination of these, that their actions should be given a higher judicial standard of review than a purely private action. "The test is whether there is a sufficiently close nexus between the State and the challenged action of the regulated entity that the action of the latter may fairly be treated as that of the State itself."[115]

While a number of state courts have held that even private hospitals must afford fair procedures or due process in their administrative proceeding, only three of these states' courts have considered the specific issue of the right to representation by counsel. Those three states are New Jersey, Hawaii, and California. The cases from these three states will be considered chronologically.

The earliest case is the 1967 New Jersey appellate level decision, Sussman v. Overlook Hospital.[116] In Sussman, the defendant, a private hospital, rejected the applications for staff privileges from two neurosurgeons without giving any reason for its action. The hospital also denied their requests for a hearing. The defendant took "the position that it is a private hospital and its board of trustees has the absolute discretion to reject the application of any doctor for staff privileges."[117]

An earlier New Jersey decision, however, had found that approval or disapproval of staff membership applications was a "fiduciary power to be exercised reasonably and for the public good."[118] Thus, the Sussman court found that some procedural protections were mandatory before requests for privileges could be finally denied. The Sussman court then grappled with the issue of what procedures the hospital must afford the two physicians to ensure a fair determination of their applications. The court concluded that, at the least, the physicians were to be allowed to appear in person, present witnesses, and submit documentary evidence.

On the issue of representation by counsel, the court said, ". . .it is not essential that plaintiffs be afforded the right to confront and cross-examine witnesses or to be represented by counsel in the presentation of their case. It is within the discretion of the board of trustees as to whether counsel may attend the hearing and participate in the proceedings."[119]

The next case came from the Supreme Court of Hawaii in 1972, Silver v. Castle Memorial Hospital.[120] Dr. Silver, a neurosurgeon, sued Castle Memorial Hospital for conspiracy, defamation, and antitrust violations after his staff privileges were not renewed by the hospital board. Because the defendant hospital received federal construction funds, the court determined that it must afford Dr. Silver procedural due process.[121] While the three voting

judges concurred on this point, they differed on what particular due process rights had to be afforded.

Justice Kobayashi, writing the lead opinion, indicated that for the purposes of due process requirements, the distinction between public hospitals and private hospitals receiving public funds was meaningless.[122] He then enumerated in some detail what procedural rights he found were necessary to satisfy the requirements of due process.[123]

On the specific issue of the right to representation by counsel, he said:

> It should be within the discretion of the hospital board as to whether counsel may attend the hearing and participate in the proceedings. Participation of counsel would probably not be necessary unless the hospital's attorney is used in the proceedings or the extreme nature of the charges involved indicated that representation by an attorney would be advantageous. Such a limitation would not preclude a doctor from consulting an attorney prior to the hearing even though the attorney was not allowed to participate in the hearing itself.[124]

In his concurring opinion, Justice Levinson indicated that the dictates of due process required going further with respect to the physician's right to counsel. He wrote, "In addition to timely notice and a written statement of the specific charges against him, I would hold that a physician is entitled to the

representation of counsel. . . ."[125]

Justice Abe concurred that the private hospital in this case was subject to the requirements of the due process clause. He came to an anomalous conclusion, however. He thought that since the state held the power to determine medical competency through its licensing regulations, that all hospitals should be required to give staff privileges to any licensed physician who applied for them. If a physician was thought incompetent, then the matter should be referred to the state's procedures for reviewing competency for license.

In the 1974 California decision, Ascherman v. San Francisco Medical Society,[126] a surgeon brought an action against three private hospitals and numerous individuals. The hospitals had all permanently suspended his staff privileges. The surgeon, Dr. Ascherman, alleged, among other things, that the hospitals did not afford him due process. In addressing the due process issue, the California court quoted extensively with approval from J. Kobayashi's opinion in Silver, including his language on representation by counsel.[127] No mention was given to J. Levinson's concurring opinion. Ascherman is the first of four California state cases which ruled against the right of representation by counsel.

The next state court case was also from California, Anton v. San Antonio Community Hospital[128] Dr. Anton, a surgeon, brought a writ of mandamus to compel the

defendant, a private hospital, to reinstate his privileges and reappoint him to the medical staff.[129] The hospital bylaws provided for representation by another physician at privileging hearings or representation by counsel with the approval of the hospital's judicial review committee. Dr. Anton failed to request representation by counsel before his hearing, yet he raised the issue before the court.

The court noted Dr. Anton's failure to request representation by counsel. The court then cited Ascherman and Silver for the proposition that ". . .rendering representation by counsel a matter of discretion of the judicial review committee--is not offensive to the standard of "minimal due process" which is applicable to proceedings of this kind."[130]

The first state court decision to hold unequivocally that a health care provider has a right to counsel was a 1979 New Jersey case, Garrow v. Elizabeth General Hospital[131] Dr. Garrow was a pediatric surgeon who applied for privileges at the defendant hospital. The Medical Organization Committee recommended to the Board of Trustees that Dr. Garrow not be given privileges. Dr. Garrow was notified of the committee's recommendation. He was further advised of his right to a hearing before the Board of Trustees, which was empowered to make the final decision.

Dr. Garrow requested a hearing, but before it took place he brought suit against the hospital in state court. He alleged, among other things, that the hearing

procedures the Board of Trustees used to make its privileging decisions were legally defective because they did not allow for representation by counsel. The New Jersey Supreme Court agreed with him. In so doing, the court not only overruled the earlier New Jersey Sussman decision,[132] but it recognized that new ground was being broken in the face of opposite holdings in Anton and Silver.[133]

The Garrow court contemplated a somewhat restricted role for counsel:

> It may be that counsel's role may be limited, for cross-examination and confrontation of adverse witnesses will not necessarily occur. However, the attorney, in addition to being in a position to advise the client during the hearing, will have the opportunity to present evidence on his behalf, to meet and explain adverse data, and to present argument to the board. In view of the physician's substantial interest in proceedings of this nature, on balance, we believe that the physician should have the right to have counsel present at mandated hospital hearings with respect to his application for admission to the staff. Counsel's participation and his role will be subject to the reasonable rules laid down by the Hospital's board of trustees or other authorized persons and management and control of the hearings will rest with the person or persons in charge. In this manner hearers "can assure that delaying tactics and other abuses sometimes present in the traditional adversary trial

> situation do not occur." We have no doubt that counsel will conduct himself within the established framework. Whether or not to have counsel will be the physician's choice.[134] (citations omitted)

The last two state court decisions which considered the representation issue were both from California: Cipriotti v. Board of Directors of Northridge,[135] decided in 1983, and Gill v. Mercy Hospital,[136] decided in 1988. Both cases relied upon the earlier California decisions to hold against the right of representation by counsel. Neither case took note of the Garrow decision.

In sum, only three of the state courts that require private hospitals to grant procedural safeguards in their privileging actions have considered the issue of representation by counsel. Those three courts are split on the issue. California does not require representation. New Jersey requires that health care providers be allowed counsel if they so choose. The two justices on the Hawaii Supreme Court who addressed the issue were split: one left it to hospital authorities to decide if the health care provider was allowed counsel, the other would grant counsel as a matter of due process right. Given the flexible, ad hoc nature of determining due process rights, a split of opinions is understandable.

3. The right to legal counsel in the Army's adverse privileging hearings.

The three factors we must balance when determining which due process rights are required in a given case involving the potential deprivation of constitutionally-protected interests apply to the Army's adverse privileging hearings as well. First, as noted above, health care providers have important and valuable interests in their clinical privileges. The Army's suspension or revocation of clinical privileges may effectively deprive health care providers of their livelihood.

Second, whether the participation of legal counsel is needed or useful to prevent the erroneous deprivation of these interests varies with each health care provider's ability to defend himself or herself. The participation of legal counsel may be so necessary and useful in many instances. "[T]he presence of attorneys can help structure the proceedings and may be instrumental in obtaining a fair result, particularly if the facts in the case are very complicated, or numerous witnesses and documents may be involved. This is especially true if the physician whose privileges are at issue is upset or agitated or is incapable or handling the matter on his own behalf."[137]

Third, we must consider the burden of permitting legal counsel to speak at these hearings. As noted in Section II, the new quality assurance regulation

implicitly permits military legal counsel to attend and consult with military health care providers at the hearing. To adequately prepare to consult with the provider, counsel has already spent most of the time necessary to prepare to speak for the provider. The hearing committee now receives its own legal advice from the servicing judge advocate office.[138] Military and civilian health care providers could obtain civilian counsel at their own expense. Thus the burden on the Army would be small.

Not all hospital commanders are eager to have lawyers in their domain. On the other hand, experience has also shown a growing appreciation by hospital commanders, and other senior Army health care providers and administrators, for the growing complexity of the legal aspects of their work. These officers are aware of the National Practitioners Data Bank and the devastating effect that an adverse privileging action can have on a health care provider's career.

Many of these officers fear that allowing lawyers to represent health care providers before hearing committees will turn professional peer review into wrangles over legal technicalities. Some experience, and a little preparation by the hearing committee chairperson, in consultation with the servicing judge advocate, will soon overcome this fear. To ensure that the hearing committee procedures do not break down into an adversarial wrangle over legal technicalities, I propose that the Army regulation have a qualifying proviso similar to the Navy's, quoted in Section VII

below. Such a proviso should assure the hearing committee chairperson's control over the proceedings.

In view of the health care providers' substantial interest in the outcome of adverse privileging proceedings, the necessary and useful benefits of permitting counsel to participate, and the small burden on Army that granting this right would cause, on balance, providers should have the right to have counsel speak for them if they so choose.

V. UNION REPRESENTATION

In American Federation of Government Employees, Local 1941 v. Federal Labor Relations Authority,[139] (hereafter AFGE) the United States Court of Appeals for the District of Columbia held that an Army civilian physician may, upon request, have a union representative present with him at hearing committee meetings. The basis of the court's decision was its interpretation of 5 United States Code 7114(a)(2)(B) (1982). This statute provides for the right to have a union representative present at an examination reasonably believed by the employee to result in disciplinary action.

The physician in the case, Dr. Hanna, was an opthalmologist employed at the Noble Army Hospital, Ft. McClellan, Alabama. He was suspended from practice in September 1984 following an audit of his patient

records. The auditing opthalmologist concluded that: "Dr. Hanna had used outdated treatment techniques; he had rendered poor medical care in general; and the majority of case records audited contained deficient evaluation and documentation."[140]

Based upon the audit report, the credentials committee scheduled a meeting of the hearing committee to review the case and make recommendations to the hospital commander. After proper notification of the hearing, Dr. Hanna indicated that he would attend the meeting with his lawyer. He also asked to have a representative of his union attend with him. The request to have a union representative was denied, and the meeting went forward. At the hearing Dr. Hanna represented himself.

After hearing the evidence, the hearing committee recommended that Dr. Hanna's clinical privileges be restricted. The hospital commander adopted the hearing committee's recommendations and advised Dr. Hanna of his right to appeal. Dr. Hanna did not appeal; he resigned, and later that year he died.

Dr. Hanna's case was taken into federal court by his union under the legal theory that the union had a derivative right--as the bargaining unit for the civilian health care providers at the hospital--to have a representative present at the hearing. The circuit court, relying on NLRB v. Weingarten, Inc.,[141] held that health care providers did have a right to have a union representative at the hearing committee

proceedings. The Weingarten case contemplates an active role by the union representative at such meetings.[142]

In an apparent response to the AFGE decision, the drafters of the Army's new medical quality assurance regulation, AR 40-68, have provided for union representation at hearing committee proceedings. The regulation reads:

> During an investigation or hearing under this regulation, the exclusive representative of an appropriate bargaining unit has the right to be present under the following conditions:
>
> (a) Whenever a civilian employee of the unit is the subject, practitioner, or witness during the proceedings.
>
> (b) If requested by the employee and if the employee reasonably believes that the inquiry could lead to disciplinary action against him or her. Unless required by the collective bargaining agreement, there is no requirement to advise the employee of this right. If the employee requests the presence of the exclusive representative, a reasonable amount of time will be allowed to obtain him or her. The servicing civilian personnel office and labor counselor will be consulted before denying such a request. The role of the union representative is not wholly passive, although he or she will not be permitted to make the proceedings adversarial.

> Subject to the direction of the hearing committee chairperson, the union representative may be permitted to explain the employee's position (if the employee agrees) or to persuade the employee to cooperate in the proceedings.[143]

The potential role of the union representative is not well mapped in this regulation. Hearing committee proceedings are never supposed to be adversarial, yet the health care provider is allowed to present documentary evidence, examine, and cross-examine witnesses. These activities might reasonably be considered as "explaining" the employee's position. Similarly, nowhere in the regulation is provision made for the health care provider to make an opening or closing statement before the hearing committee. Experience shows, however, that such statements are regularly part of the hearing proceedings. Making opening and closing statements may be considered "explaining" the employee's position. Apparently, the union representative, who may be a lawyer by training, could represent the health care provider in a number of ways that the provider's own legal counsel currently may not.

A respondent's right to have a spokesperson at an administrative hearing adds one more procedural due process protection to important property and liberty interests. There is no equitable reason why Army civilian health care providers who are represented by unions should enjoy greater procedural rights than non-represented providers and active duty providers.

The current regulation allows legal counsel to be present with the health care provider at the hearing committee proceedings.[144] The role of legal counsel should be expanded to allow counsel to speak for the health care provider.

VI. THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

The earlier discussion on due process considered the Act's reporting requirements. Congress was concerned that physicians were failing to carry out effective peer review for fear of being sued by those being reviewed. To counter this fear, Congress created a broad immunity from liability for participants of adverse privileging actions. As a prerequisite for gaining the immunity, the Act requires that certain due process standards be met to protect the rights of the subject health care providers as well.

Among the due process standards required to obtain the immunity protection under the Act are adequate and fair hearing procedures.[145] Assuming the health care provider requests a hearing in a timely fashion, the hearing will be deemed adequate if, among other rights, "in the hearing the physician involved has the right to representation by an attorney or other person of the physician's choice."[146]

It is not essential, however, that the health care facility strictly follow the specific due process

requirements set forth in the Act in order to have an adequate hearing. Congress was aware that some courts had enumerated different due process requirements for procedures in decisions regarding clinical privileges. If the due process requirements spelled out by the courts are complied with, then the hospital and the participants still qualify for the broad immunity from liability.[147]

Additionally, it is unclear to what extent Congress intended the Act's due process standards to apply to DOD clinical privilege actions. The due process standards were intended to work in conjunction with the broad immunity from liability provided to participants in the professional review process. This protection is unnecessary for DOD personnel, as Congress provided similar immunity for the military services under separate legislation the same year in which it enacted the Act.[148]

On the other hand, there is good reason to think that the same due process standards for an adequate hearing should and will apply to DOD. It was Congress' "intent that physicians receive fair and unbiased review to protect their reputations and medical practices."[149] DOD physicians have similar liberty and property interests in their reputations and medical practices as their civilian counterparts. The DOD personnel who participate in the privileging action are given a similar immunity as their civilian

counterparts. Given these similarities, DOD physicians should receive the same due process protections as their civilian counterparts.

More important, the draft DOD Directive being considered to implement DOD participation in the Act requires the military departments to "prepare regulations and establish standards for professional peer review actions and appeal procedures of professional peer actions using guidance provided for in" the Act.[150] If the language of the published DOD Directive coincides with that in the draft, then the Army will need to ensure that its privileging regulation allows for due process standards in line with those of the Act.

Assuming that the Army should meet or will need to meet the Act's due process standards, would the Army then need to allow for legal representation at adverse privileging hearings? The answer would depend on where the adverse privileging action took place. As noted above, the Act does not require that a hospital strictly follow its due process standards in order to have an adequate hearing. If the due process rights enumerated by the courts are met, the hearing will also be adequate for immunity purposes.

As discussed in Section IV, only three state courts have considered the issue of representation. Under the applicable law in California, the Army's hospital at Fort Ord would not need to grant this procedural right. At the hospital at Fort Dix, New Jersey, on the

other hand, the applicable law mandates that the right to legal representation be given. There is no equitable reason why the Army should give its health care providers in one state less due process protection for the same administrative hearing than other Army providers would receive in other states. All Army health care providers should be given the option to have legal representation.

VII. THE OTHER MILITARY SERVICES

Both the Navy[151] and the Air Force[152] allow their health care providers representation by legal counsel at adverse privileging hearings. In its Credentials Committee Fair Hearing Board Guide, the Navy gives boilerplate language for the credentials committee chairman to read to the responding health care provider. Among the rights that the chairman explains to the health care provider are the following:

> First, you have the right to appear before this Committee, with or without counsel. In your absence, you may be represented by counsel at all open proceedings of the Board. You may have military counsel of your own choice, provided proper authority determines the counsel requested is reasonably available. Additionally, you may employ civilian counsel at your own expense. Second . . . your counsel may question any voting member to determine whether a basis for challenge exist. . . .

> You and your counsel may question any witnesses who appear before the committee.
> If you or your counsel have any objections to any matter introduced, or to any of the proceedings of this Committee, you or your counsel may state your objections and the reasons for it.[153]

The Navy guide also contains a qualifying proviso on the right to counsel.

> There is no absolute right to the assistance of counsel at this hearing. As a matter of policy, your counsel has been permitted to attend and represent you before this Committee. However, that permission may be withdrawn and your counsel may be asked to leave the hearing if his/her presence impedes the Committee in performing its duties.[154]

The Air Force regulation does not contain the helpful boilerplate language to guide the credentials committee chairman. The chairman, however, does advise the responding health care provider of "the right to consult and be represented by military legal counsel (applies to military members only)."[155] The Air Force health care provider may also hire civilian legal counsel at the provider's own expense.

In addition to DOD, the Veterans Administration (VA) is the other federal agency which provides health care on a large scale.[156] VA health care providers have a statutory right to be represented by legal counsel at adverse privileging hearings.[157]

There is no apparent reason why the Army should afford its health care providers less due process protections than their counterparts in the other military services or the VA. This inequity in procedural rights is particularly glaring at Joint Military Medical Commands (JMMCs). JMMCs were created to try to cut medical costs in areas served by more than one military health care system. For example, in San Antonio, Texas, Army and Air Force health care providers serve side by side in MTFs separately owned by the two services and operated under a single (Air Force) command. One set of rules is imposed on all health care providers to carry out their medical duties. However, each service enforces its clinical privileging regulations on its health care providers.[188] As discussed above, the Army grants one less right procedural for its health care providers than the Air Force grants: the right to be represented by counsel.

VIII. REPRESENTATION ANOMALIES IN THE ARMY

The Army and the American people have a very large financial investment in Army health care providers. For example, it is common knowledge within the Army Medical Department (AMEDD) that the vast majority of active duty Army physicians had some or all of their medical school education paid for at taxpayer expense. In order to induce these physicians to stay in the

volunteer force once their educational payback is completed, they are given special pay[159] on top of the basic pay that other Army officers receive. Where shortages in specialty areas require it, the Army often contracts with civilian physicians at two or three times the pay of their military counterparts. With this in mind, consider the following.

The possible ramifications of an adverse privileging action for an active duty Army health care provider include elimination from military service.[160] Specific provision has been made in Army regulation for this contingency:

> While not all inclusive, existence of one of the following or similar conditions, unless successfully rebutted, authorizes elimination of an officer due to misconduct, moral or professional dereliction or in the interests of national security:
> . . .(9) Conduct or actions resulting in loss of a professional status, such as withdrawal, suspension or abandonment of professional license, endorsement, or certification which is directly or indirectly connected with the performance of one's military duties and necessary for the (sic) performance, including withdrawal of clinical privileges for Army Medical Department (AMEDD) officers.[161]

Those AMEDD officers subject to an elimination procedure may elect to appear before a board of inquiry.[162] The purpose of the board "is to afford

the respondent a fair and impartial hearing to determine whether he should be retained in the Army. It is the responsibility of the Government to establish by a preponderance of evidence that the officer has failed to maintain the standard desired for his grade and branch or that he conducted himself in a manner prejudicial to national security."[163]

Ironically, among the rights afforded to the Medical Corps officer who elects to appear before the board of inquiry is to be:

> Provided with a counsel who is an officer of the Judge Advocate General's Corps; or allowed to obtain civilian counsel of his own selection with no expense to the Government, provided that procurement of his own counsel does not result in unreasonable delay. . . . If provided with counsel who is a member of the Judge Advocate General's Corps, the counsel may be an individual requested by the officer if reasonably available, as determined by the major commander of the requested counsel.[164]

Thus, the Army allows for representation by counsel at an elimination action that is based on an adverse privileging action where no such representation is allowed. Since elimination from the service is all but a foregone conclusion once clinical privileges are withdrawn, it seems more equitable to give the health care provider greater procedural due process rights at the earlier proceedings.

Like Army health care providers, Army aviators are subject to peer review procedures when there are questions as to their professional competence. Yet unlike the health care providers, responding aviators are allowed representation by legal counsel, military or civilian, at their hearings.[165] That is not equitable.

Numerous Army separation regulations provide for representation by counsel before boards. Examples include separation actions for failure to meet weight standards,[166] personality disorders,[167] parenthood,[168] personal abuse of alcohol or other drugs,[169] unsatisfactory performance,[170] a pattern of misconduct,[171] and homosexuality.[172] The Army's interest in insuring fair procedures for soldiers facing these actions is not so much greater than that for its health care providers as to afford the former greater procedural due process protection.

IX. CONCLUSION

In this thesis I have presented the various arguments for allowing legal representation for Army health care providers at adverse privileging hearings. I have offered legal, equitable, and common sense reasons for changing the current regulation. In sum, the policy reasons for maintaining the status quo are weak. The case for changing the current policy is strong.

[1] See, e.g., Roland, Problem Physicians Elude Lax Controls, Army Times, Feb. 25, 1985, at 1, col. 2; Roland, Mayer Pledges Tougher Doctor Screening, Army times, Mar. 4, 1985, at 3, col. 1; Roland, Poor Controls Let Problem Doctors Escape Detection, Army times, Mar. 11, 1985, at 3, col. 1; Roland, Army Accepted Psychiatrist With Revoked License, Army Times, Mar. 18, 1985, at 8, col. 1; Robinson, The Mess in Military Medicine, Reader's Digest, Feb. 1985, at 49; Starr & Miller, Military Medicine, Newsweek, July 29, 1985, at 18; NBC Nightly News, (NBC television broadcast, Jan. 10, 1985) (transcript in possession of Major Charles).

[2] See, e.g., Stewart, Military Medicine, plagued by scandal, tries to cure itself, Atlantic Constitution, Oct. 6, 1985 at 1; Roland, Authorities Failed to Relieve Surgeon Accused of Drinking, Army Times, Mar. 11, 1985, at 2, col. 1.

[3] Medical malpractice actions against the United States are cognizable under the Federal Torts Claims Act, 28 U.S.C. 2671-2680.

[4] See Medical Malpractice Claims by Armed Forces Personnel: Hearings on H.R. 1942 Before the Subcommittee on Administrative Law and Government Relations of the Committee of the Judiciary, 98th Cong., 1st Sess. 16-24 (1983) (statement by Mary Day, President, CAMI of Rhode Island); Military Medical Malpractice: Hearings on H.R. 1161 Before the Subcommittee on Administrative Law and Governmental Relations of the Committee of the Judiciary, 99th

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Cong., 1st Sess. (1985). These hearing minutes contain the testimony and prepared statements of numerous CAMI members.

[5] In Feres v. United States, 340 U.S. 135 (1950), the Supreme Court concluded that ". . . the Government is not liable under the Federal Tort Claims Act for injuries to servicemen where the injuries arise out of or are in the course of or are incident to service." at 146.

[6] See Military Medical Care System: Hearings Before the Subcommittee on Manpower and Personnel of the Committee on Armed Services United States Senate, 99th Cong., 1st Sess. 1-7 (1985) (statement of Senator Pete Wilson) 185-203 (1985) (statement of Senator James Sasser).

[7] Dep't of Defense Directive 6025.11, DOD Health Care Provider Credentials Review and Clinical Privileging (May 20, 1988) [hereinafter DOD Dir. 6025.11].

[8] Army Reg. 40-68, Quality Assurance Administration (19 January 1990) [hereinafter AR 40-68].

[9] Rosen, Thinking About Due Process, The Army Lawyer, Mar. 1988, at 3 [hereinafter Rosen].

[10] M. MacDonald, K. Meyer & B. Essig. Health Care Law: A Practical Guide, at 15-45 (1988).

[11] 10 U.S.C. 1073.

[12] DOD Dir. 6025.11, para. D1.

[13] DOD Dir. 6025.11, Definitions.

[14] AR 40-68, Glossary. All military and civilian physicians and nurses in the United States are supposed to be licensed by a state. See generally AR 40-68, Chapter 4. The state license by itself is not enough to allow its holder to practice medicine or dentistry in a hospital. It may suffice to allow its holder to carry out a private office practice. Today's highly technical and specialized medical practice requires, in most instances, that health care providers have access to hospital care for their patients. Clinical privileges are thus indispensable for most health care providers.

[15] DOD Dir. 6025.11, para. E2.

[16] AR 40-68, para. 1-4c(1).

[17] See supra notes 1 and 6.

[18] AR 40-68, para. 4-1f.

[19] Id. at para. 4-1i.

[20] The national medical specialty boards perform four functions. First, they "certify" physician competence by administering rigorous testing on a volunteer basis. Second, the boards serve an educational role by disseminating professional materials and by sponsoring seminars and conferences. Their third function is to detail the clinical knowledge and skills of their particular specialty. Last, the national boards act as lobbying agents for their members.

[21] E.g., the recently superceded Army Reg. 40-66,
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Medical Record and Quality Assurance Administration, para. 9-10 (31 Jan. 1985). The term "individually credential" is a misnomer. Credentials are "[t]he documents which constitute evidence of training, licensure, experience, and expertise of a practitioner." AR 40-68, Section II. Terms. Credentials are reviewed to determine what particular clinical privileges the health care provider may qualify for.

[22] AR 40-68, para. 4-1b.

[23] Id.

[24] Id. at para. 4-1c.

[25] Id. at para. 4-2a(1).

[26] Id. at para. 4-2a(2).

[27] Id. at para. 4-2a(3). A PCF contains information on the health care provider's education, training, relevant experience, and past clinical ratings. See Id. at para. 4-11

[28] Id. at para. 4-2a(4).

[29] Id. at para. 4-2a(5).

[30] Id. at para. 4-1d.

[31] Id. at para. 2-1b(3) and (4).

[32] Id. at para. 2-1b(4).

[33] Id. at paras. 4-1 and 4-2. The credentials committee is to reconsider the status of each

Footnote continued on next page.

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clinically privileged health care provider every two years. Id. at paras. 4-1g and 4-8e.

[34] Id. at para. 4-9g(3).

[35] DOD Dir. 6025.11, para. F2. This paragraph directs facility commanders to report these acts and what command action was taken in response to them through channels to DOD. By implication, DOD expects the facility commander to at least consider taking adverse clinical action under these circumstances.

[36] Id. at Enclosure 7 and AR 40-68, para. 4-9k(5).

[37] See generally AR 40-68, para. 3-3.

[38] Id. at para. 3-2. The Quality Assurance Program covering DTFs is governed by Chapter 5.

[39] Id. at para. 3-5h.

[40] See, e.g., Id. at paras. 3-5b(2) and 3-5e(7).

[41] Id. at para. 4-2b(3)-(5).

[42] Id. at para. 4-9b(1)(a).

[43] Id.

[44] Id. at para. 4-9b(1)(b)

[45] Id. at para. 4-9b(3).

[46] Id. at para. 4-9e and Figure 4-1.

[47] Id. at para. 4-9c(1).

[48] Id. at para. 4-9c(2).

[49] Id. at Figure 4-1. A new privileging wrinkle under AR 40-68 is the "abeyance" status. Abeyance allows the health care provider to perform nonclinical duties during the period while the investigation into the facts of the summary action are being investigated. If not adverse privileging action is deemed appropriate, the health care provider can return to clinical duties without there ever without there ever being a record of an adverse action. See paras. 4-2b(2) and 4-9b(1)(b).

[50] AR 40-68 does not indicate who has the authority to determine the members of the hearing committee for any particular hearing.

[51] AR 40-68, para. 4-9f(9).

[52] Id. at para. 4-9f(1).

[53] Id.

[54] Id. at para. 4-9f(2) and Figure 4-3.

[55] Id. at para. 4-9f(3).

[56] AR 40-68, para. 4-9f(5).

[57] Id. at paras. 4-9f(6) and (8).

[58] Id. at paras. 4-9f(6) and 4-9h.

[59] Id. at para. 4-9f(7).

[60] Id. at para. 4-9g(1).

[61] Id. at para. 4-9g(2).

[62] Id. at para. 4-10.

[63] Id. at para. 4-10a. In CONUS the appeals authority is the Commander, U.S. Army Health Services Command. In Europe the appeals authority is the Commander, 7th MEDCOM. In the Far East, the appeals authority is the Commander, 18th MEDCOM.

[64] Id. at para. 4-10c.

[65] Id. at para. 4-10f.

[66] The fifth amendment due process clause pertains to deprivations of life, liberty, or property by the federal government. The fourteenth amendment extended the same obligation of due process to the states.

[67] Rosen, 3, n.1 (quoting R. Rotunda, J. Nowak & J. Young, Treatise on Constitutional Law 13 (1986).

[68] Dep't of Army, Pam. 27-21, Administrative Law, para. 4-1b (1 Oct. 1985) [hereinafter DA Pam. 27-21].

[69] Other issues of procedural due process in adverse hearing might include: "sufficiency of the notice of charges; the right of the physician to discover in advance the evidence against him possessed by the hospital; the burden of proof at the hearing; the right of cross-examine witnesses; . . . .the partiality and composition of the hearing panel; the timeliness of the hearing; and the right of the hospital to summarily suspend a physician from the staff prior to the hearing." Southwick, The Elusive Concept of Procedural Due Process, The Hospital Medical Staff, June 1978, at 20 [hereinafter Southwick].

[70] DA Pam. 27-21, para. 4-2b(2).

[71] See generally DA Pam 27-21, para. 4-2.

[72] Paul v. Davis, 424 U.S. 693, 701 (1976).

[73] Rich v. Secretary of the Army, 735 F.2d 1220, 1227 (10th Cir. 1984).

[74] Codd v. Velger, 429 U.S. 624 (1977).

[75] 42 U.S.C. 11101-11152 (1987).

[76] Id. at 11101(2).

[77] E.g., Patrick v. Burget, 180 S.Ct. 1659 (1988). See also, Curran, Legal Immunity for medical peer-review programs: new policies explored, 320 New Engl. J. Med. 233 (1989).

[78] Id. at 11152(b). See also, Lynch, National Data Bank: The Army's Implementation of the Health Care Improvement Act of 1986, OSJA HSC Medicolegal.

[79] For example, in the Army, "[i]nquiry will also be made to the National Practitioner Data Bank prior to initial granting of clinical privileges." AR 40-68, para. 4-1f. See also para. 4-13f.

[80] 42 U.S.C. 11152(b).

[81] Memorandum for Deputy Assistance Secretary of the Army (MP,EO&HR), 26 Oct. 1987, J. Jarrett Clinton, M.D., Deputy Assistant Secretary (PA&QA), OASD, subject: Memorandum of Understanding between DoD and the Department of Health and Human Services.

[82] DOD officials originally contemplated an

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instruction but have upgraded it to a directive. The directive's contemplated publication date is fall 1990. Telephone interview with Navy Captain Schwartz, Office of the Assistant Secretary of Defense (PA&QA) (Feb. 23, 1990).

[83] The Act provides that the information to be reported to and then disseminated from the Data Bank includes the health care provider's name and a description of the acts or omissions for the adverse privileging action. 42 U.S.C. 11133(a)(3).

[84] DA Pam. 27-21, para. 4-2b(3).

[85] The reporting mechanism of the Act is mandatory for physicians and permissive for other privileged health care providers, 42 U.S.C. 11133(a).

[86] 42 U.S.C. 11101(2).

[87] Message, HQ Dep't of Army, DASG-PSQ, 291235Z Oct 87, subject: Reporting of Malpractice Claims; Message, HQ Dep't of Army, JACS-TCD, 131630Z Nov 87, subject: Reporting of Malpractice Claims.

[88] 42 U.S.C. 11135(b).

[89] Even without the Act, The Army Surgeon General's Office currently will disseminate information on adverse privileging actions to state licensing agencies and requesting health care facilities.

[90] 670 F.2d 507 (5th Cir. 1982).

[91] Id. at 511.

[92] The 5th circuit later thus expressed this property interest in Daly v. Sprague, 675 F.2d 716, 727 (5th Cir. 1982).

[93] Northeast Georgia Radiological Assoc. at 511 (emphasis added). See also Daly v. Sprague, 675 F.2d 716, 727 (5th Cir. 1982).

[94] AR 40-68, para. 4-9f(2).

[95] DA Pam 27-21, para. 4-3c(2).

[96] Mathews v. Eldredge, 424 U.S. 319, 335 (1976).

[97] Friendly, Some Kind of Hearing, 123 U.Pa. L. Rev. 1267, 1278 (1975).

[98] Compare Jenkins v. McKeithen, 395 U.S. 411 (1969) and Mempa v. Rhay, 389 U.S. 128 (1967) with Anonymous Nos. 6 and 7 v. Baker, 360 U.S. 287 (1959), Madera v. Board of Education, 386 F.2d 778 (C.A.2, 1967), cert. denied, 390 U.S. 1028, and Dixon v. Alabama State Bd. of Educ., 294 F.2d 150 (C.A. 5), cert. denied, 368 U.S. 930 (1961).

[99] See generally Annotation, Exclusion of or Discrimination Against Physician or Surgeon by Hospital, 37 A.L.R. 3rd, 645 (1971), and Southwick, supra.

[100] Id.

[101] 447 F.2d 839 (5th Cir. 1971).

[102] Woodbury at 844.

[103] E.g., Board of Regents v. Roth, 408 U.S.

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Continued from previous page. 564 (1972), where the court analyzed the liberty interest of the fifth and fourteenth amendments; See also, Mathews v. Eldredge, 424 U.S. 319 (1976), where the court set forth the three factors to be balanced to determine when a particular procedural right is required.

[104] No. 82-10171 (E.D. Mich. Nov. 1983) (Memorandum Opinion and Order).

[105] I am aware of an Army case where the responding physician, a Puerto Rican, was allowed to have civilian legal counsel speak for him at his adverse privieging hearing. The hospital command decided that the physician was unable to adequately represent own interests because of poor English language skill. My family members and I have been treated in CONUS MTFs on a numbers of occasions by physicians who appeared to have quite poor English language skills.

[106] 825 F.2d 1016 (6th Cir. 1987), cert. denied, 108 S.Ct. 2015.

[107] Yashon at 1026.

[108] Id.

[109] Ginsburg & Diller, Medical Staff Hearing and Questions of Due Process, Right to Counsel, and Liability, 2 Whittier L. Rev. 683, 690 (1980). This reference is to Gideon v. Wainwright, 372 U.S. 335, where the Supreme Court held that there is a

Footnote continued on next page.

Continued from previous page. sixth amendment right to legal counsel in criminal cases, applicable to the states through the fourteenth amendment.

[110] See Annotation supra note 100.

[111] Id. at 661.

[112] Compare Applebaum v. Bd. of Directors of Barton Mem., 163 Cal Rptr. 831, 836 (Cal. Ct. App.), with Zonerich v. Overlook Hosp., 514 A.2d 53, 57 (N.J.Supra.A.D. 1986).

[113] E.g., Greisman v. Newcomb Hospital, 193 A.2d 817 (N.J. 1983).

[114] E.g., federal money received under the Hill-Burton Act, 42 U.S.C. 291, for private hospital construction or expansion.

[115] People v. Parkview Memorial Hosp., Inc., 536 N.E. 2d 274, 276 (Ind. 1989).

[116] 231 A.2d 389 (N.J. Super. Ct. App. Div. 1967).

[117] Id. at 391.

[118] See supra note 114 at 824.

[119] Sussman at 391.

[120] 497 P.2d 564, cert. denied, 409 U.S. 1048 (1972), rehg. denied, 409 U.S. 1131 (1973).

[121] See supra note 115.

[122] Silver at 569-571.

[123] Id. at 571, 572.

[124] Id.

[125] Id. at 575.

[126] Cal. App. 3d Supp. 623 (Cal. Ct. App. 1974).

[127] Id. at 649, 649.

[128] 567 P.2d 1162 (1977).

[129] The Anton followed Ascherman in finding that a private hospital was required to give the same minimum due process protections as a public hospital, Anton at 1168.

[130] Anton at 1177.

[131] 401 A.2d 533 (N.J. Sup. Ct. 1979).

[132] See Supra note 117.

[133] Garrow at 542.

[134] Id.

[135] 196 Cal. App. 2d. 367 (Cal Ct. App. 1983).

[136] 199 Cal. App. 3d 889

[137] See supra note 10.

[138] AR 40-68, para. 4-9f.(11).

[139] 837 F.2d 495 (D.C. Cir. 1988)

[140] AFGE at 497.

[141] 420 U.S. 251 (1975).

[142] Id. at 263, n.7.

[143] AR 40-68, para. 4-9f(4).

[144] See supra note 56.

[145] 5 U.S.C. 11112(a)(3).

[146] 5 U.S.C. 11112(b)(3)(C)(i). The failure of the peer review body to meet this condition or any other conditions does not, by itself, constitute failure to meet the standards required for adequate notice and hearing, 11112(b)(3)(D). There is a presumption, rebuttable "by a preponderance of the evidence," having met the standards, 11112(a).

[147] See 1986 U.S. Code Cong. & Admin. News 6393.

[148] 10 U.S.C. 1102g.

[149] See supra note 147.

[150] Telephone interview with Navy Captain Schwartz, Office of the Assistant Secretary of Defense (PA&QA) (Feb. 23, 1990).

[151] Commander, Naval Medical Command Instruction 6320.8, para. 6-5c(5) and Appendix Q, pages Q-2 and Q-3.

[152] Air Force Regulation 168-13, 31 May 1984, para. 8-13b(2)(f) and (g) [hereinafter AFR 168-13].

[153] See supra, note 152, Appendix.

[154] Id.

[155] AFR 168-13, para. 8-13b(2)(f).

[156] The only other federal health care agency is the Public Health Service (PHS). The PHS directs a diverse number of health care programs, from sophisticated National Institutes of Health research to the Indian Health Service, which operates small primary and secondary health clinics on isolated indian reservations. The IHS, which is the largest component of the PHS, does not have a service-wide policy on representation by counsel at adverse privileging hearings. Unlike the military services and the VA, the IHS does not have legal counsel readily available at its health care facilities.

[157] 38 U.S.C. 4110(c).

[158] Telephone interview with LTC Timothy P. Williams, Risk Management Consultant, Office of the Deputy Chief of Staff for Clinical Services, U.S. Army Health Services Command (Mar. 12, 1990).

[159] Department of Defense, Military Pay and Allowances, Entitlements Manual, NAVSO P-6048, 9 March 1989, Chapter 5, Special Pay for Medical Officers.

[160] AR 40-68, para. 4-9h.

[161] AR 635-100, Personnel Separations: Officer Personnel, para. 5-12a(11).

[162] Id. at paras. 5-14c(3) and 5-19b(4).

[163] Id. at para. 5-32.

[164] Id. at para. 5-20a.

[165] Army Reg. 600-105, Personnel--General: Aviation Service of Rated Army Officers, Chapter 4 (1 Dec. 1983). The Flying Evaluation Board follow the formal procedures of Army Reg. 15-6, Boards, Commissions, and Committees: Procedures for Investigating Officers and Boards of Officers (24 Aug. 1977).

[166] AR 635-200, Personnel Separations: Enlisted Personnel, para. 5-15 (15 June 1989) [hereinafter AR 635-200]. Paragraph 2-10b(1) provides the right to counsel advisement for the applicable AR 635-200 chapters.

[167] Id. at para. 5-13.

[168] Id. at para. 5-8.

[169] Id. at Chapter 9.

[170] Id. at Chapter 13.

[171] Id. at para. 14-12b.

[172] Id. at Chapter 15.